Division of Licensing and Protection
103 South Main Street
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

March 5, 2015

Ms. Mary Pappas, Administrator
King's Daughters Home, Inc.
10 Rugg Street
St Albans, VT 05478-1713

Dear Ms. Pappas:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 9, 2015.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:jl

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0056	A. BUILDING: _____ B. WING _____	C 02/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS HOME, INC.	10 RUGG STREET ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R100	Initial Comments: An unannounced onsite complaint investigation was completed by the Division of Licensing and Protection on 2/9/15. Based on information gathered, regulatory violations were cited as follows.	R100		
R164 SS=F	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions: (2) A registered nurse must delegate the responsibility for the administration of specific medications to designated staff for designated residents This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the registered nurse (RN) failed to delegate the responsibility for the administration of specific medications to 6 of 8 designated staff for designated residents. Findings include: 1. During record review and interview at approximately 10:40 AM on 2/9/15, the RN identified 8 current unlicensed employees who have the responsibility for administering medications to residents. The RN was not able to provide written evidence of delegation to 6 of 8 employees, and the RN verbally confirmed that 6 of the 8 unlicensed employees had not been delegated by him/her to administer specific medications to designated residents.	R164	Upon the hire of a new RN, added to their job duties will be retraining + redelegation to administer medications of current employees and written evidence of such will be maintained in front of mar + in nurses station. This requirement will be done within 10 days of new RN's hire date, stating that current employees are trained + delegated to administer meds to designated residents unless he/she deems as new rules are trained + delegated their name + date of training + delegation will be added to delegation list. effective 2/28/15.	

Division of Licensing and Protection
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mary J Pappas
TITLE: Administrator
(X6) DATE: 2/28/15

R164-R224 POC accepted 3/2/15 ltsm RN/pmc

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0056	A. BUILDING: _____ B. WING _____	C 02/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS HOME, INC.	10 RUGG STREET ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R171	Continued From page 1	R171		
R171 SS=E	V. RESIDENT CARE AND HOME SERVICES 5.10 Medication Management 5.10.g Homes must establish procedures for documentation sufficient to indicate to the physician, registered nurse, certified manager or representatives of the licensing agency that the medication regimen as ordered is appropriate and effective. At a minimum, this shall include: (1) Documentation that medications were administered as ordered; (2) All instances of refusal of medications, including the reason why and the actions taken by the home; (3) All PRN medications administered, including the date, time, reason for giving the medication, and the effect; (4) A current list of who is administering medications to residents, including staff to whom a nurse has delegated administration; and (5) For residents receiving psychoactive medications, a record of monitoring for side effects. (6) All incidents of medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to maintain a current list of who is administering medications to residents, including staff to whom a nurse has delegated administration. Findings include: 1. During record review and interview at approximately 10:40 AM on 2/9/15, the registered nurse (RN) identified 8 current unlicensed	R171	The Administrator will require the RN to maintain a list of current employees who have been trained & delegated to administer medications to residents under her license. This list will be maintained in front of MAR & in nurses station effective 2/28/15.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0056	A. BUILDING: _____ B. WING _____	C 02/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS HOME, INC.	10 RUGG STREET ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R171	Continued From page 2 employees who have the responsibility for administering medications to residents. The RN was not able to provide a written list of unlicensed employees to whom s/he had delegated the responsibility to administer specific medications to designated residents.	R171		
R206 SS=D	V. RESIDENT CARE AND HOME SERVICES 5.18 Reporting of Abuse, Neglect or Exploitation 5.18.a The licensee and staff shall report any case of suspected abuse, neglect or exploitation to the Adult Protective Services (APS) as required by 33 V.S.A. §6903. APS may be contacted by calling toll-free 1-800-564-1612. Reports must be made to APS within 48 hours of learning of the suspected, reported or alleged incident. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the licensee and staff failed to report a case of suspected exploitation to Adult Protective Services (APS) as required by 33 V. S. A. 6903 within the 48 hours of learning of the alleged incident, for 1 of 5 residents in the applicable sample (Resident #1). Findings include: 1. Per record review on 2/9/15, the home's administrator documented (on 10/2/14) having received a report of possible medication diversion by staff regarding the narcotic medications for Resident #1. The administrator conducted an internal investigation and made a mandatory report to the Vermont Board of Nursing. However, per verbal confirmation midday on 2/9/15, the	R206		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0056	A. BUILDING: _____ B. WING _____	C 02/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS HOME, INC.	10 RUGG STREET ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R206	Continued From page 3 administrator stated a lack of awareness of the requirement to also report the allegations to APS.	R206	The licensee shall report ANY SUSPECTED abuse to the licensing agency with 48 hours (2 days) of learning of the suspected, reported or alleged incident even if unable to prove. effective 2/28/15	
R224 SS=E	VI. RESIDENTS' RIGHTS 6.12 Residents shall be free from mental, verbal or physical abuse, neglect, and exploitation. Residents shall also be free from restraints as described in Section 5.14. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the home failed to assure that all residents, 1 of 5 in the applicable sample (Resident #1) remained free from exploitation. Findings include: 1. Per record review and staff interview on 2/9/15, the administrator terminated, on 11/4/14, the employment of an unlicensed staff person who had admitted to diverting the narcotic medications for Resident #1 for personal use. Records showed that during the period July to October, 2014, Resident #1 had a physician's order for morphine 15 milligrams every four hours as needed for pain. Records indicated that Resident #1 had taken acetaminophen for pain management during the day shift, and also had a topical patch (fentanyl) for pain. Resident #1 was documented as being given morphine for pain (noted as 9 out of 10 on pain scale) on the evening shift routinely during the same period. When the physician questioned the refill order and inquired about use rates for the morphine in late September, the home began an internal investigation which ultimately revealed that at least one staff member had been diverting the	R224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0056	A. BUILDING: _____ B. WING _____	C 02/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KING'S DAUGHTERS HOME, INC.	10 RUGG STREET ST ALBANS, VT 05478

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R224	Continued From page 4	R224	The administrators will require that medication management will be reviewed weekly by facility RN to ensure that administration of all medications are given accordingly based on physicians orders and the changing needs of the residents within the facility effective 2/28/15.	

not until a later date

morphine for personal use and falsified the Medication Administration Record (MAR) of Resident #1. The physician decided to discontinue the morphine order; the pain had been and was continued to be managed with acetaminophen and a topical pain patch (fentanyl). There was no evidence to indicate that Resident #1 had suffered unmedicated pain during the period of diversion. Nonetheless, the medication oversight measures in place during the period July to October, 2014 failed to identify or prevent the diversion of controlled medication prescribed for Resident #1. The administrator confirmed on 2/9/15 that one staff person had been terminated and reported to the Vermont Board of Nursing for admitted medication diversion from Resident #1 to personal use.

not accurate

This report is not accurate in its findings. For clarification, the employment of an unlicensed staff person was terminated to admitting to using street drugs while not at work. This administer did not find out that this employee diverted Resident #1's medication until a later date of 2-10-15 as a report from Office of Professional Regulation investigation was received, although it was suspected. As soon as this employee admitted to using street drugs, she was terminated and an investigation by office of Professional Regulation followed.